List of Subjects

42 CFR Part 412

Administrative practice and procedure, Health facilities, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

42 CFR Part 413

Health facilities, Kidney diseases, Medicare, Puerto Rico, Reporting and recordkeeping requirements.

For the reasons set forth in the preamble, 42 CFR chapter IV is proposed to be amended as follows:

PART 412--PROSPECTIVE PAYMENT SYSTEMS FOR INPATIENT HOSPITAL SERVICES

A. Part 412 is amended as set forth below:

1. The authority citation for part 412 continues to read as follows:

Authority: Secs. 1102 and 1871 of the Social Security Act (42 U.S.C. 1302 and 1395hh).

Subpart A--General Provisions

2. Section § 412.1 is revised to read as follows:

§ **412.1 Scope of part.**

(a) Purpose. (1) This part implements sections 1886(d) and (g) of the Act by establishing a prospective payment system for the operating costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1983 and a prospective payment system for the capital-related costs of inpatient hospital services furnished to Medicare beneficiaries in cost reporting periods beginning on or after October 1, 1991. Under these prospective payment systems, payment for the operating and capital-related costs of inpatient hospital services furnished by hospitals subject to the systems (generally, short-term, acute-care

hospitals) is made on the basis of prospectively determined rates and applied on a per discharge basis. Payment for other costs related to inpatient hospital services (organ acquisition costs incurred by hospitals with approved organ transplantation centers, the costs of qualified nonphysician anesthetist's services, as described in § 412.113(c), and direct costs of approved nursing and allied health educational programs) is made on a reasonable cost basis. Payment for the direct costs of graduate medical education is made on a per resident amount basis in accordance with § 413.86 of this chapter. Additional payments are made for outlier cases, bad debts, indirect medical education costs, and for serving a disproportionate share of low-income patients. Under either prospective payment system, a hospital may keep the difference between its prospective payment rate and its operating or capital-related costs incurred in furnishing inpatient services, and the hospital is at risk for inpatient operating or inpatient capital-related costs that exceed its payment rate.

(2) This part implements section 1886(j) of the Act by establishing a prospective payment system for the inpatient operating and capital costs of inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation

hospital or rehabilitation unit that meets the conditions of § 412.604.

(b) Summary of content. (1) This subpart describes the basis of payment for inpatient hospital services under the prospective payment systems specified in paragraph (a)(1) of this section and sets forth the general basis of these systems.

(2) Subpart B sets forth the classifications of hospitals that are included in and excluded from the prospective payment systems specified in paragraph (a)(1) of this section, and sets forth requirements governing the inclusion or exclusion of hospitals in the systems as a result of changes in their classification.

(3) Subpart C sets forth certain conditions that must be met for a hospital to receive payment under the prospective payment systems specified in paragraph (a)(1) of this section.

(4) Subpart D sets forth the basic methodology by which prospective payment rates for inpatient operating costs are determined under the prospective payment system specified in paragraph (a)(1) of this section.

(5) Subpart E describes the transition rate-setting methods that are used to determine transition payment rates for inpatient operating costs during the first 4 years of

the prospective payment system specified in paragraph (a)(1) of this section.

(6) Subpart F sets forth the methodology for determining payments for outlier cases under the prospective payment system specified in paragraph (a)(1) of this section.

(7) Subpart G sets forth rules for special treatment of certain facilities under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(8) Subpart H describes the types, amounts, and methods of payment to hospitals under the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs.

(9) Subpart K describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient operating costs is implemented for hospitals located in Puerto Rico.

(10) Subpart L sets forth the procedures and criteria concerning applications from hospitals to the Medicare Geographic Classification Review Board for geographic redesignation under the prospective payment systems specified in paragraph (a)(1) of this section.

(11) Subpart M describes how the prospective payment system specified in paragraph (a)(1) of this section for inpatient capital-related costs is implemented effective with reporting periods beginning on or after October 1, 1991.

(12) Subpart P describes the prospective payment system specified in paragraph (a)(2) of this section for rehabilitation hospitals and rehabilitation units and sets forth the general methodology for paying for the operating and capital costs of inpatient hospital services furnished by rehabilitation hospitals and rehabilitation units effective with cost reporting periods beginning on or after April 1, 2001.

Subpart B--Hospital Services Subject to and Excluded from the Prospective Payment Systems for Inpatient Operating Costs and Inpatient Capital-Related Costs

3. Section 412.20 is amended by:

A. Revising paragraph (a).

B. Redesignating paragraph (b) as paragraph (c).

C. Adding a new paragraph (b).

D. Revising the introductory text of the redesignated paragraph (c).

§ 412.20 Hospital services subject to the prospective payment systems.

(a) Except for services described in paragraphs (b)and (c) of this section, all covered inpatient hospital services furnished to beneficiaries during subject cost reporting periods are paid under the prospective payment systems specified in § 412.1(a)(1).

(b) Effective for cost reporting periods beginning on or after April 1, 2001, covered inpatient hospital services furnished to Medicare beneficiaries by a rehabilitation hospital or rehabilitation unit that meet the conditions of § 412.604 are paid under the prospective payment system described in subpart P of this part.

(c) Inpatient hospital services will not be paid under the prospective payment systems specified in § 412.1(a)(1) under any of the following circumstances:

* * * * *

4. Section 412.22 is amended by:

A. Revising paragraphs (a) and (b).

B. Revising the introductory text of paragraph (e).

C. Revising introductory text of paragraph (h)(2).

§ **412.22 Excluded hospitals and hospital units: General rules.**

(a) Criteria. Subject to the criteria set forth in paragraph (e) of this section, a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1)

of this part if it meets the criteria for one or more of the excluded classifications described in § 412.23.

(b) Cost reimbursement. Except for those hospitals specified in paragraph (c) of this section and § 412.20(b), all excluded hospitals (and excluded hospital units, as described in §§ 412.23 through 412.29) are reimbursed under the cost reimbursement rules set forth in part 413 of this subchapter, and are subject to the ceiling on the rate of hospital cost increases described in § 413.40 of this subchapter.

* * * * *

(e) Hospitals within hospitals. Except as provided in paragraph (f) of this section, for cost reporting periods beginning on or after October 1, 1997, a hospital that occupies space in a building also used by another hospital, or in one or more entire buildings located on the same campus as buildings used by another hospital, must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(h) Satellite facilities. * * *

(2) Except as provided in paragraph (h)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital that has a satellite

facility must meet the following criteria in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

5. Section 412.23 is amended by:

A. Revising the introductory text.

B. Revising the introductory text of paragraph (b).

C. Revising paragraphs introductory text of (b)(2), (b)(8), and (b)(9).

§ 412.23 Excluded hospitals: Classifications.

Hospitals that meet the requirements for the classifications set forth in this section are not reimbursed under the prospective payment systems specified in § 412.1(a)(1):

* * * * *

(b) Rehabilitation hospitals. A rehabilitation hospital must meet the following requirements to be excluded from the prospective payment systems specified in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2):

* * * * *

(2) Except in the case of a newly participating hospital seeking classification under this paragraph as a rehabilitation hospital for its first 12-month cost

reporting period, as described in paragraph (b)(8) of this section, show that during its most recent 12-month cost reporting period, it served an inpatient population of whom at least 75 percent required intensive rehabilitative services for treatment of one or more of the following conditions:

* * * * *

(8) A hospital that seeks classification under this paragraph as a rehabilitation hospital for the first full 12-month cost reporting period that occurs after it becomes a Medicare-participating hospital may provide a written certification that the inpatient population it intends to serve meets the requirements of paragraph (b)(2) of this section, instead of showing that it has treated that population during its most recent 12-month cost reporting period. The written certification is also effective for any cost reporting period of not less than one month and not more than 11 months occurring between the date the hospital began participating in Medicare and the start of the hospital’s regular 12-month cost reporting period.

(9) For cost reporting periods beginning on or after October 1, 1991, if a hospital is excluded from the prospective payment systems specified in § 412.1(a)(1) or is paid under the prospective payment system specified in

§ 412.1(a)(2) for a cost reporting period under paragraph (b)(8) of this section, but the inpatient population it actually treated during that period does not meet the requirements of paragraph (b)(2) of this section, HCFA adjusts payments to the hospital retroactively in accordance with the provisions in § 412.130.

* * * * *

6. In § 412.25, paragraph (a) introductory text and paragraph (e)(2) introductory text are revised to read as follows:

§ **412.25 Excluded hospital units: Common requirements.**

(a) Basis for exclusion. In order to be excluded from the prospective payment systems specified in § 412.1(a)(1), a psychiatric or rehabilitation unit must meet the following requirements.

* * * * *

(e) Satellite facilities. * * *

(2) Except as provided in paragraph (e)(3) of this section, effective for cost reporting periods beginning on or after October 1, 1999, a hospital unit that establishes a satellite facility must meet the following requirements in order to be excluded from the prospective payment systems specified in § 412.1(a)(1) for any period:

* * * * *

7. In § 412.29, the introductory text is revised to read as follows:

§ **412.29 Excluded rehabilitation units: Additional requirements.**

In order to be excluded from the prospective payment systems described in § 412.1(a)(1) and to be paid under the prospective payment system specified in § 412.1(a)(2), a rehabilitation unit must meet the following requirements:

* * * * *

Subpart H-- Payments to Hospitals Under the Prospective Payment Systems

8. In § 412.116, paragraph (a) is revised to read as follows:

§ 412.116 Method of payment.

(a) General rule. (1) Unless the provisions of paragraphs (b) and (c) of this section apply, hospitals are paid for hospital inpatient operating costs and capital-related costs for each discharge based on the submission of a discharge bill.

(2) Payments for inpatient hospital services furnished by an excluded psychiatric unit of a hospital (or by an excluded rehabilitation unit of a hospital for cost reporting periods beginning before April 1, 2001) are made

as described in § 413.64(a), (c), (d), and (e) of this chapter.

(3) For cost reporting periods beginning on or after April 1, 2001, payments for inpatient hospital services furnished by a rehabilitation hospital or a rehabilitation unit that meets the conditions of § 412.604 are made as described in § 412.632.

* * * * *

9. In § 412.130, paragraphs (a)(1), (a)(2), and (b) are revised to read as follows:

§ **412.130 Retroactive adjustments for incorrectly excluded hospitals and units.**

(a) Hospitals for which adjustment is made. * * *

(1) A hospital that was excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation hospital for a cost reporting period beginning on or after October 1, 1991 based on a certification under § 412.23(b)(8) of this part regarding the inpatient population the hospital planned to treat during that cost reporting period, if the inpatient population actually treated in the hospital during that cost reporting period did not meet the requirements of § 412.23(b)(2).

(2) A hospital that has a unit excluded from the prospective payment systems specified in § 412.1(a)(1) or paid under the prospective payment system specified in § 412.1(a)(2), as a new rehabilitation unit for a cost reporting period beginning on or after October 1, 1991, based on a certification under § 412.30(a) regarding the inpatient population the hospital planned to treat in that unit during the period, if the inpatient population actually treated in the unit during that cost reporting period did not meet the requirements of § 412.23(b)(2).

* * * * *

(b) Adjustment of payment. (1) For cost reporting periods beginning before April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid during the cost reporting period for which the hospital, unit, or beds were first excluded as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital

based on the exclusion and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

(2) For cost reporting periods beginning on or after April 1, 2001, the intermediary adjusts the payment to the hospitals described in paragraph (a) of this section as follows:

(i) The intermediary calculates the difference between the amounts actually paid under subpart P of this part during the cost reporting period for which the hospital, unit, or beds were first classified as a new hospital, new unit, or newly added beds under subpart B of this part, and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1) for services furnished during that period.

(ii) The intermediary makes a retroactive adjustment for the difference between the amount paid to the hospital under subpart P of this part and the amount that would have been paid under the prospective payment systems specified in § 412.1(a)(1).

Subparts N and O—-[Reserved]

10. Subparts N and O are added and reserved.

11. A new subpart P, consisting of §§ 412.600, 412.602, 412.604, 412.606, 412.608, 412.610, 412.612,

412.614, 412.616, 412.618, 412.620, 412.622, 412.624, 412.626, 412.628, 412.630, and 412.632 is added to read as follows:

Subpart P—-Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

Sec.

Subpart P--Prospective Payment for Inpatient Rehabilitation Hospitals and Rehabilitation Units

§ 412.600 Basis and scope of subpart.

(a) Basis. This subpart implements section 1886(j) of the Act, which provides for the implementation of a prospective payment system for inpatient rehabilitation hospitals and rehabilitation units (in this subpart referred to as "inpatient rehabilitation facilities").

(b) Scope. This subpart sets forth the framework for the prospective payment system for inpatient rehabilitation facilities, including the methodology used for the development of payment rates and associated adjustments, the application of a transition phase, and related rules. Under this system, for cost reporting periods beginning on or after April 1, 2001, payment for the operating and capital costs of inpatient hospital services furnished by inpatient rehabilitation facilities is made on the basis of

prospectively determined rates and applied on a per discharge basis.

§ 412.602 Definitions.

As used in this subpart--

Assessment reference date means the specific calendar day in the MDS-PAC assessment process that sets the designated endpoint of the common 3 day patient observation period, with most MDS-PAC assessment items usually referring back in time from this endpoint.

Authorized clinician means one of the following clinicians:

(1) An occupational therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(2) A physical therapist who meets the qualifications specified in § 482.56(a)(2) of this chapter.

(3) A physician who is a doctor of medicine or osteopathy and is licensed to practice medicine and surgery by the State in which the function or action is performed.

(4) A registered nurse as defined in § 484.4 of this chapter.

Discharge A Medicare patient in a inpatient rehabilitation facility is considered discharged when--

(1) The patient is formally released; or

(2) The patient dies in the inpatient rehabilitation facility.

Encode means entering data items into the fields of the computerized MDS-PAC software program .

Functional-related groups refers to the distinct groups under which inpatients are classified using proxy measurements of inpatient rehabilitation relative resource usage.

Interrupted stay means the period during which a Medicare inpatient is discharged from the inpatient rehabilitation facility and returns to the same inpatient rehabilitation facility within 3 consecutive calendar days. The 3 consecutive calendar days begin with the day of discharge.

MDS-PAC stands for the Minimum Data Set for Post Acute Care, a patient clinical assessment instrument.

Outlier payment means an additional payment beyond the standard Federal prospective payment for cases with unusually high costs.

Rural area means an area as defined in § 412.62(f)(1)(iii).

Transfer means the release of a Medicare inpatient from an inpatient rehabilitation facility to another inpatient rehabilitation facility, a short-term, acute-care

prospective payment hospital, a long-term care hospital as described in § 412.23(e), or a nursing home that qualifies to receive Medicare or Medicaid payments.

Urban area means an area as defined in § 412.62(f)(1)(ii).

§ 412.604 Conditions for payment under the prospective payment system for inpatient rehabilitation facilities.

(a) General requirements. (1) An inpatient rehabilitation facility must meet the conditions of this section to receive payment under the prospective payment system described in this subpart for inpatient hospital services furnished to Medicare beneficiaries.

(2) If an inpatient rehabilitation facility fails to comply fully with these conditions with respect to inpatient hospital services furnished to one or more Medicare beneficiaries, HCFA may, as appropriate --

(i) Withhold (in full or in part) or reduce Medicare payment to the inpatient rehabilitation facility until the facility provides adequate assurances of compliance; or

(ii) Classify the inpatient rehabilitation facility as an inpatient hospital that is subject to the conditions of subpart C of this part and is paid under the prospective payment systems specified in § 412.1(a)(1).

(b) Inpatient rehabilitation facilities subject to the prospective payment system. An inpatient rehabilitation facility must meet the criteria to be classified as a rehabilitation hospital or rehabilitation unit set forth in §§ 412.23(b), 412.25, and 412.29 for exclusion from the inpatient hospital prospective payment systems specified in § 412.1(a)(1).

(c) Completion of patient assessment instrument. For each Medicare patient admitted or discharged on or after April 1, 2001, the inpatient rehabilitation facility must complete a patient assessment instrument in accordance with § 412.606.

(d) Limitation on charges to beneficiaries. (1) Prohibited charges. Except as provided in paragraph (d)(2) of this section, an inpatient rehabilitation facility may not charge a beneficiary for any services for which payment is made by Medicare, even if the facility's costs of furnishing services to that beneficiary are greater than the amount the facility is paid under the prospective payment system.

(2) Permitted charges. An inpatient rehabilitation facility receiving payment under this subpart for a covered hospital stay (that is, a stay that includes at least one covered day) may charge the Medicare beneficiary or other

person only for the applicable deductible and coinsurance amounts under §§ 409.82, 409.83, and 409.87 of this subchapter.

(e) Furnishing of inpatient hospital services directly or under arrangement. (1) The applicable payments made under this subpart are payment in full for all inpatient hospital services, as defined in § 409.10 of this chapter, other than physicians' services to individual patients reimbursable on a reasonable cost basis (in accordance with the criteria of § 415.102(a) of this subchapter).

(2) HCFA does not pay any provider or supplier other than the inpatient rehabilitation facility for services furnished to a Medicare beneficiary who is an inpatient, except for physicians' services reimbursable under § 405.550(b) of this chapter and services of an anesthetist employed by a physician reimbursable under § 415.102(a) of this subchapter.

(3) The inpatient rehabilitation facility must furnish all necessary covered services to the Medicare beneficiary either directly or under arrangements (as defined in § 409.3 of this subchapter).

(f) Reporting and recordkeeping requirements. All inpatient rehabilitation facilities participating in the prospective payment system under this subpart must meet the

recordkeeping and cost reporting requirements of §§ 413.20 and 413.24 of this subchapter.

§ 412.606 Patient assessment.

(a) Admission orders. At the time that each Medicare patient is admitted, the inpatient rehabilitation facility must have physician orders for the patient's care during the time the patient is hospitalized.

(b) Patient assessment instrument. An inpatient rehabilitation facility must use the MDS-PAC instrument to assess Medicare inpatients who--

(1) Are admitted on or after April 1, 2001; or

(2) Were admitted before April 1, 2001, and are still inpatients as of April 1, 2001.

(c) Comprehensive assessments. (1) An inpatient rehabilitation facility's authorized clinician must perform a comprehensive, accurate, standardized, and reproducible assessment of each Medicare inpatient using the MDS-PAC as part of his or her patient assessment in accordance with the schedule described in § 412.610.

(2) A clinician employed or contracted by an inpatient rehabilitation facility must record appropriate and applicable data accurately and completely for each MDS-PAC item.

(3) The assessment process must include--

(i) Direct patient observation and communication with the patient; and

(ii) When appropriate and to the extent feasible, patient data from the patient's physician(s), family, friends, the patient's clinical record, and other sources.

(4) The authorized clinician, must sign the MDS-PAC attesting to its completion and accuracy.

§ 412.608 Patient rights regarding MDS-PAC data collection.

(a) Before performing an assessment using the MDS-PAC, an authorized clinician must inform the Medicare inpatient of the following patient rights:

(1) The right to be informed of the purpose of the MDS-PAC data collection;

(2) The right to have the MDS-PAC information collected be kept confidential and secure;

(3) The right to be informed that the MDS-PAC information will not be disclosed to others, except for legitimate purposes allowed by the Federal Privacy Act and Federal and State regulations;

(4) The right to refuse to answer MDS-PAC questions; and

(5) The right to see, review, and request changes on his or her MDS-PAC assessment.

(b) The inpatient rehabilitation facility must ensure

that an authorized clinician documents in the Medicare inpatient's clinical record that the patient was informed of the patient rights specified in paragraph (a) of this section.

(c) The patient rights specified in paragraph (a) of this section are in addition to the patient rights specified under the conditions of participation for hospitals in § 482.13 of this chapter.

§ 412.610 Assessment schedule.

(a) General. For each Medicare inpatient an inpatient rehabilitation facility must submit MDS-PAC assessment data that covers a time period that is in accordance with the assessment schedule specified in paragraph (c) of this section.

(b) Starting the assessment schedule day count. The first day that the inpatient is furnished Medicare-covered services during his or her current inpatient rehabilitation facility hospital stay is counted as day one of the MDS-PAC assessment schedule.

(c) Assessment reference dates. With respect to the patient's current hospitalization, an inpatient rehabilitation facility must indicate on the MDS-PAC one of the following assessment reference dates:

(1) Day 4 MDS-PAC assessment. For the assessment that covers calendar days 1 through 3 of the patient's current hospitalization, the date that is the 3rd calendar day after the patient started being furnished Medicare-covered Part A services.

(2) Day 11 MDS-PAC assessment. For the assessment that covers calendar days 8 through 10 of the patient's current hospitalization, the date that is the 10th calendar day after the patient started being furnished Medicare-covered Part A services.

(3) Day 30 MDS-PAC assessment. For the assessment that covers calendar days 28 through 30 of the patient's current hospitalization, the date that is the 30th calendar day after the patient started being furnished Medicare-covered Part A services.

(4) Day 60 MDS-PAC assessment. For the assessment that covers calendar days 58 through 60 of the patient's current hospitalization, the date that is the 60th calendar day after the patient started being furnished Medicare-covered Part A services.

(5) Discontinuation of Medicare-covered Part A services assessment. For the assessment that is completed when the inpatient is not discharged from the inpatient rehabilitation facility but stops receiving Medicare-covered

Part A services, the actual date that the inpatient stops receiving Medicare-covered Part A services.

(6) Discharge assessment. For the assessment that is completed when the Medicare inpatient is discharged from the inpatient rehabilitation facility, the actual date of discharge from the inpatient rehabilitation facility.

(d) Late MDS-PAC assessment reference date. If the MDS-PAC assessment reference date is entered later than the assessment reference date specified in paragraph (c)(1) of this section, the MDS-PAC assessment reference date is considered late.

(1) If the MDS-PAC assessment reference date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(2) If the MDS-PAC assessment reference date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

(e) Completion and encoding dates. (1) The Day 4, Day 11, Day 30, and Day 60 MDS-PAC assessments must be completed 1 calendar day after the MDS-PAC assessment reference date that is recorded on the MDS-PAC.

(2) The discharge MDS-PAC assessment must be completed on the 5th calendar day in the period beginning with the MDS-PAC assessment reference date.

(3) All MDS-PAC assessments must be encoded by the 7th calendar day in the period beginning with the MDS-PAC completion date that is recorded on the MDS-PAC.

(f) Accuracy of the MDS-PAC data. The encoded MDS-PAC assessment data must accurately reflect the patient's clinical status at the time of the MDS-PAC assessment.

(g) MDS-PAC record retention. An inpatient rehabilitation facility must maintain all MDS-PAC patient data sets completed within the previous 5 years in a paper format in the patient's clinical record or in an electronic computer file that the inpatient rehabilitation facility can easily obtain.

§ 412.612 Coordination of MDS-PAC data collection.

(a) Responsibilities of the authorized clinician. An inpatient rehabilitation facility's authorized clinician who has participated in performing an MDS-PAC patient assessment must have responsibility for--

(1) The accuracy and thoroughness of the patient's MDS-PAC assessment; and

(2) The accuracy of the date inserted in the attestation section of the MDS-PAC.

(b) Certification. An inpatient rehabilitation facility's authorized clinician must certify the accuracy and completion date of the MDS-PAC assessment by signing and dating the appropriate lines of the MDS-PAC.

(c) Signatures. Any clinician who contributes data for an MDS-PAC item must sign and date the appropriate lines of the MDS-PAC.

(d) Penalty for falsification. (1) Under Medicare an individual who knowingly and willfully --

(i) Certifies a material and false statement in a patient assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

(ii) Causes another individual to certify a material and false statement in a patient assessment is subject to a civil money penalty of not more than $5,000 for each assessment.

(2) Clinical disagreement does not constitute a material and false statement.

§ 412.614 Transmission of MDS-PAC data.

(a) Data format. The inpatient rehabilitation facility must encode and transmit data for each Medicare inpatient–-

(1) Using the computerized version of the MDS-PAC available from HCFA; or

(2) Using a computer program(s) that conforms to the HCFA standard electronic record layout, data specifications, and data dictionary, includes the required MDS-PAC data set, and meets other HCFA specifications.

(b) How to transmit data. The inpatient rehabilitation facility must--

(1) Electronically transmit complete and encoded MDS-PAC data for each Medicare inpatient to the HCFA MDS-PAC system in accordance with the data format specified in paragraph (a) of this section; and

(2) Transmit data using electronic communications software that provides a direct telephone connection from the inpatient rehabilitation facility to the HCFA MDS-PAC system.

(c) Transmission dates. All MDS-PAC assessments must be transmitted to HCFA MDS-PAC system by the 7th calendar day in the period beginning with the last permitted MDS-PAC encoding date.

(d) Late transmission penalty. (1) HCFA assesses a penalty when an inpatient rehabilitation facility does not transmit the required MDS-PAC data to the HCFA MDS-PAC system in accordance with the transmission timeframe in paragraph (c) of this section.

(2) If the actual MDS-PAC transmission date is later

than the transmission date specified in paragraph (a) of this section the MDS-PAC data is considered late.

(i) If the MDS-PAC transmission date is late by 10 calendar days or fewer, the inpatient rehabilitation facility receives a payment rate that is 25 percent less than the payment rate associated with a case-mix group.

(ii) If the MDS-PAC transmission date is late by more than 10 calendar days, the inpatient rehabilitation facility receives no payment.

§ 412.616 Release of information collected using the MDS-PAC.

(a) General. An inpatient rehabilitation facility may release information from the MDS-PAC only as specified in § 482.24(b)(3) of this chapter.

(b) Release to the inpatient rehabilitation facility's agent. An inpatient rehabilitation facility may release information that is patient-identifiable to an agent only in accordance with a written contract under which the agent agrees not to use or disclose the information except for the purposes specified in the contract and only to the extent the facility itself is permitted to do so under paragraph (a) of this section.

§ **412.618 Interrupted stay.**

For purposes of the MDS-PAC assessment process, if a

Medicare patient has an interrupted stay the following applies:

(a) Assessment requirements. (1) The initial case-mix group classification from the Day 4 MDS-PAC assessment remains in effect (that is, no new Day 4 MDS-PAC assessment is performed).

(2) The required scheduled MDS-PAC Day 11, Day 30, and Day 60 assessments must be performed.

(3) When the patient is discharged, a discharge MDS-PAC assessment must be performed.

(b) Recording and encoding of data. The authorized clinician must record the interrupted stay data on the interrupted stay tracking form of the MDS-PAC.

(c) Transmission of data. The data recorded on the interrupted stay tracking form must be transmitted to the HCFA MDS-PAC system within 7 calendar days of the date that the Medicare patient returns to the inpatient rehabilitation facility.

(d) Revised assessment schedule. (1) If the interrupted stay occurs before the Day 4 assessment, the assessment reference dates, completion dates, encoding dates, and data transmission dates for the Day 4 and Day 11 MDS-PAC assessments are advanced by the same number of calendar days as the length of the patient's interrupted

stay.

(2) If the interrupted stay occurs after the Day 4 assessment and before the Day 11 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 11 MDS-PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(3) If the interrupted stay occurs after the Day 11 and before the Day 30 assessment, then the assessment reference date, completion date, encoding date, and data transmission date for the Day 30 MDS-PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

(4) If the interrupted stay occurs after the Day 30 and before the Day 60 assessment then the assessment reference date, completion date, encoding date, and data transmission date for the Day 60 MDS-PAC assessment are advanced by the same number of calendar days as the length of the patient's interrupted stay.

§ 412.620 Patient classification system.

(a) Classification methodology. (1) A patient classification system is used to classify patients in inpatient rehabilitation facilities into mutually exclusive case-mix groups.

(2) For the purposes of this subpart, case-mix groups are classes of Medicare patient discharges by functional-related groups that are based on a patient's impairment, age, comorbidities, functional capabilities, and other factors that may improve the ability of the functional-related groups to estimate variations in resource use.

(3) Data from Day 4 assessments under § 412.610(c)(1) are used to classify a Medicare patient into an appropriate case-mix group.

(b) Weighting factors. (1) General. An appropriate weight is assigned to each case-mix group that measures the relative difference in facility resource intensity among the various case-mix groups.

(2) Short-stay outliers. HCFA will determine a weighting factor or factors for patients that are discharged and not transferred within a number of days from admission as specified by HCFA.

(3) Patients who expire. HCFA will determine a weighting factor or factors for patients who expire within a number of days from admission as specified by HCFA.

(c) Revision of case-mix group classifications and weighting factors. HCFA may periodically adjust the case-mix groups and weighting factors to reflect changes in--

(1) Treatment patterns;

(2) Technology;

(3) Number of discharges; and

(4) Other factors affecting the relative use of resources.

§ 412.622 Basis of payment.

(a) Method of payment. (1) Under the prospective payment system, inpatient rehabilitation facilities receive a predetermined amount per discharge for inpatient services furnished to Medicare beneficiaries.

(2) The amount of payment under the prospective payment system is based on the Federal payment rate, including adjustments described in § 412.624 and, during a transition period, on a blend of the Federal payment rate and the facility-specific payment rate described in § 412.626.

(b) Payment in full. (1) The payment made under this subpart represents payment in full (subject to applicable deductibles and coinsurance as described in subpart G of part 409 of this subchapter) for inpatient operating and capital costs associated with furnishing Medicare covered services in an inpatient rehabilitation facility, but not for the cost of an approved medical education program described in §§ 413.85 and 413.86 of this chapter.

(2) In addition to payments based on prospective payment rates, inpatient rehabilitation facilities receive payments for the following--

(i) Bad debts of Medicare beneficiaries, as provided in § 413.80 of this chapter, and

(ii) A payment amount per unit for blood clotting factor provided to Medicare inpatients who have hemophilia.

§ 412.624 Methodology for calculating the Federal prospective payment rates.

(a) Data used. To calculate the prospective payment rates for inpatient hospital services furnished by inpatient rehabilitation facilities HCFA uses --

(1) The most recent Medicare data available, as of the date of establishing the inpatient rehabilitation facility prospective payment system, used to estimate payments for inpatient operating and capital costs made under part 413 under this subchapter ;

(2) An appropriate wage index to adjust for area wage differences;

(3) An increase factor to adjust for the most recent estimate of increases in the prices of an appropriate market basket of goods and services included in covered inpatient rehabilitation services; and

(4) Patient assessment data described in § 412.606 and

other data that account for the relative resource utilization of different patient types.

(b) Determining the average costs per discharge for fiscal year 2000. HCFA determines the average inpatient operating and capital costs per discharge for which payment is made to each inpatient rehabilitation facility using the available data under paragraph (a)(1) of this section. The cost per discharge is adjusted to fiscal year 2000 by an increase factor, described in paragraph (a)(3) of this section, under the update methodology described in section 1886(b)(3)(B)(ii) of the Act for each year through the midpoint of fiscal year 2000.

(c) Determining the Federal prospective payment rates.

(1) General. The Federal prospective payment rates will be established using a standard payment amount referred to as the budget neutral conversion factor. The budget neutral conversion factor is a standardized payment amount based on average costs from a base year which reflects the combined aggregate effects of the weighting factors, various facility and case level adjustments and other adjustments.

(2) Update the cost per discharge.

(i) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's cost per discharge determined under paragraph (b) of this section to

compute the cost per discharge for fiscal year 2001. Based on the updated cost per discharge, HCFA estimates the payments that would have been made to the facility for fiscal year 2001 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(ii) HCFA applies the increase factor described in paragraph (a)(3) of this section to the facility's fiscal year 2001 cost per discharge determined under paragraph (c)(2)(i) of this section to compute the cost per discharge for fiscal year 2002. Based on the updated cost per discharge, HCFA estimates the payments that would have been made to the facility for fiscal year 2002 under part 413 of this chapter without regard to the prospective payment system implemented under this subpart.

(3) Computation of the budget neutral conversion factor. The budget neutral conversion factor is computed as follows:

(i) For fiscal years 2001 and 2002. Based on the updated costs per discharge and estimated payments for fiscal years 2001 and 2002 determined in paragraphs (c)(2)(i) and (c)(2)(ii) of this section, HCFA computes a budget neutral conversion factor for fiscal years 2001 and 2002, as specified by HCFA, that reflects, as appropriate,

the adjustments described in paragraph (d) of this section.

(ii) For fiscal years after 2002. The budget neutral conversion factor for fiscal years after 2002 will be the standardized payments for the previous fiscal year updated by the increase factor described in paragraph (a)(3) of this section including adjustments, described in paragraph (d) of this section, as appropriate.

(4) Determining the Federal prospective payment rate for each case-mix group. The Federal prospective payment rates for each case-mix group is the product of the weighting factors described in § 412.620(b) and the budget neutral conversion factor described in paragraph (c)(3) of this section.

(d) Adjustments to the budget neutral conversion factor. The budget neutral conversion factor described in paragraph (c)(3) of this section will be adjusted for--

(1) Outlier payments. HCFA determines a reduction factor equal to the estimated proportion of additional outlier payments described in paragraph (e)(4) of this section.

(2) Budget neutrality. HCFA adjusts the Federal prospective payment rates for fiscal years 2001 and 2002 so that aggregate payments under the prospective payment system are estimated to equal 98 percent of the amount that would

have been made to inpatient rehabilitation facilities under part 413 of this subchapter without regard to the prospective payment system implemented under this subpart.

(3) Coding and classification changes. HCFA adjusts the budget neutral conversion factor for a given year if HCFA determines that revisions in case-mix classifications or weighting factors for a previous fiscal year (or estimates that such revisions for a future fiscal year) did result in (or would otherwise result in) a change in aggregate payments that are a result of changes in the coding or classification of patients that do not reflect real changes in case-mix.

(e) Calculation of the adjusted Federal prospective payment. For each discharge, an inpatient rehabilitation facility's Federal prospective payment is computed on the basis of the Federal prospective payment rate determined under paragraph (c) of this section. A facility's Federal prospective payment rate will be adjusted, as appropriate, to account for area wage levels, payments for outliers and transfers, and for other factors as follows:

(1) Adjustment for area wage levels. The labor portion of a facility's Federal prospective payment is adjusted to account for geographical differences in the area wage levels using an appropriate wage index. The

application of the wage index is made on the basis of the location of the facility in an urban or rural area as defined in § 412.602.

(2) Adjustments for low income patients. HCFA adjusts the Federal prospective payment, on a facility basis, for the proportion of low income patients that receive inpatient rehabilitation services as determined by HCFA.

(3) Adjustments for rural areas. HCFA adjusts the Federal prospective payment by a factor, as specified by HCFA, to account for the higher costs per patient in facilities located in rural areas as defined in § 412.602.

(4) Adjustment for high cost outliers. HCFA provides for an additional payment to a facility if its estimated costs for a patient exceeds a fixed dollar amount (adjusted for area wage levels, and factors to account for treating low income patients and for rural locations) as specified by HCFA. The additional payment equals 80 percent of the difference between the estimated cost of the patient and the sum of the adjusted Federal prospective payment computed under this section and the adjusted fixed dollar amount.

(5) Adjustments related to the MDS-PAC. An adjustment to a facility's Federal prospective payment amount for a given discharge will be made if --

(i) The assessment reference date identified on the

MDS-PAC as described in § 412.610(d) is late; and

(ii) The transmission of MDS-PAC data as described in § 412.614(d) is late.

(f) Special payment provision for patients that are transferred.

(1) A facility's Federal prospective payment will be adjusted to account for a discharge of a patient who --

(i) Is transferred from the inpatient rehabilitation facility to another site of care,; and

(ii) Stays in the facility for a number of days that is less than the average length of stay for non-transfer cases in the case-mix group to which the patient is classified.

(2) HCFA calculates the adjusted Federal prospective payment for patients who are transferred in the following manner:

(i) By dividing the Federal prospective payment by the average length of stay for non-transfer cases in the case-mix group to which the patient is classified to equal the payment per day.

(ii) By multiplying the payment per day under paragraph (f)(2)(i) of this section by the number of days the patient stayed in the facility prior to being discharged to equal the unadjusted payment amount.

(iii) By applying the adjustments described in paragraphs (e)(1), (e)(2), and (e)(3) of this section to the unadjusted payment amount determined in paragraph (f)(2)(ii) of this section.

§ 412.626 Transition period.

(a) Duration of transition period and proportions of the blended transition rate. (1) For cost reporting periods beginning on or after April 1, 2001 through fiscal year 2002, inpatient rehabilitation facilities receive a payment comprised of a blend of the adjusted Federal prospective payment, as determined in § 412.624(e) or § 412.624(f) and, and a facility-specific payment as determined in paragraph (b) of this section.

(i) For cost reporting periods beginning on or after April 1, 2001 and before fiscal year 2002, payment is based on 66**b** percent of the facility-specific payment and 33**a** percent of the adjusted Federal prospective payment.

(ii) For cost reporting periods beginning in fiscal year 2002, payment is based on 33**a** percent of the facility-specific payment and 66**b** percent of the adjusted Federal prospective payment.

(2) For cost reporting periods beginning with fiscal year 2003 and after, payment is based entirely on the adjusted Federal prospective payment.

(b) Calculation of the facility-specific payment. The facility-specific payment is equal to the payment for each cost reporting period in the transition period that would have been made without regard to this subpart. The facility's Medicare fiscal intermediary calculates the facility-specific payment for inpatient operating costs and capital costs in accordance with part 413 of this chapter.

§ 412.628 Publication of the Federal prospective payment rates.

HCFA publishes information pertaining to the inpatient rehabilitation facility prospective payment system effective for each fiscal year in the **Federal Register**. This information includes the unadjusted Federal payment rates, the patient classification system and associated weighting factors, and a description of the methodology and data used to calculate the payment rates. This information is published on or before August 1 prior to the beginning of each fiscal year.

§ 412.630 Limitation on review.

Administrative or judicial review under sections 1869 or 1878 of the Act, or otherwise, is prohibited with regard to the establishment of the methodology to classify a patient into the case-mix groups and the associated weighting factors, the unadjusted Federal per discharge

payment rates, additional payments for outliers and special payments, and the area wage index.

§ 412.632 Method of payment under the inpatient rehabilitation facility prospective payment system.

(a) General rule. Subject to the exceptions in paragraphs (b) and (c) of this section, inpatient rehabilitation facilities receive payment under this subpart for inpatient operating costs and capital costs for each discharge only following submission of a discharge bill.

(b) Periodic interim payments. (1) Criteria for receiving periodic interim payments. (i) An inpatient rehabilitation facility receiving payment under this subpart may receive periodic interim payments (PIP) for Part A services under the PIP method subject to the provisions of § 413.64(h) of this subchapter.

(ii) To be approved for PIP, the inpatient rehabilitation facility must meet the qualifying requirements in § 413.64(h)(3) of this subchapter.

(iii) Payments to a rehabilitation unit are made under the same method of payment as the hospital of which it is a part as described in § 412.116.

(iv) As provided in § 413.64(h)(5) of this chapter, intermediary approval is conditioned upon the intermediary's best judgment as to whether payment can be made under the

PIP method without undue risk of its resulting in an overpayment to the provider.

(2) Frequency of payment. For facilities approved for PIP, the intermediary estimates the inpatient rehabilitation facility's Federal prospective payments net of estimated beneficiary deductibles and coinsurance and makes biweekly payments equal to 1/26 of the total estimated amount of payment for the year. If the inpatient rehabilitation facility has payment experience under the prospective payment system, the intermediary estimates PIP based on that payment experience, adjusted for projected changes supported by substantiated information for the current year. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this subchapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final settlement.

(3) Termination of PIP. (i) Request by the inpatient rehabilitation facility. Subject to paragraph (b)(1)(iii) of this section, an inpatient rehabilitation facility receiving PIP may convert to receiving prospective payments

on a non-PIP basis at any time.

(ii) Removal by the intermediary. An intermediary terminates PIP if the inpatient rehabilitation facility no longer meets the requirements of § 413.64(h) of this chapter.

(c) Interim payments for Medicare bad debts and for Part A costs not paid under the prospective payment system. For Medicare bad debts and for costs of an approved education program and other costs paid outside the prospective payment system, the intermediary determines the interim payments by estimating the reimbursable amount for the year based on the previous year's experience, adjusted for projected changes supported by substantiated information for the current year, and makes biweekly payments equal to 1/26 of the total estimated amount. Each payment is made 2 weeks after the end of a biweekly period of service as described in § 413.64(h)(6) of this chapter. The interim payments are reviewed at least twice during the reporting period and adjusted if necessary. Fewer reviews may be necessary if an inpatient rehabilitation facility receives interim payments for less than a full reporting period. These payments are subject to final cost settlement.

(d) Outlier payments. Additional payments for outliers are not made on an interim basis. The outlier

payments are made based on the submission of a discharge bill and represent final payment.

(e) Accelerated payments. (1) General rule. Upon request, an accelerated payment may be made to an inpatient rehabilitation facility that is receiving payment under this subpart and is not receiving PIP under paragraph (b) of this section if the inpatient rehabilitation facility is experiencing financial difficulties because of the following:

(i) There is a delay by the intermediary in making payment to the inpatient rehabilitation facility.

(ii) Due to an exceptional situation, there is a temporary delay in the inpatient rehabilitation facility's preparation and submittal of bills to the intermediary beyond its normal billing cycle.

(2) Approval of payment. An inpatient rehabilitation facility's request for an accelerated payment must be approved by the intermediary and HCFA.

(3) Amount of payment. The amount of the accelerated payment is computed as a percentage of the net payment for unbilled or unpaid covered services.

(4) Recovery of payment. Recovery of the accelerated payment is made by recoupment as inpatient rehabilitation facility bills are processed or by direct payment by the

inpatient rehabilitation facility.

B. Part 413 is amended as set forth below:

PART 413 - PRINCIPLES OF REASONABLE COST REIMBURSEMENT; PAYMENT FOR END-STAGE RENAL DISEASE SERVICES; PROSPECTIVELY DETERMINED PAYMENT FOR SKILLED NURSING FACILITIES

1. The authority citation for part 413 is revised to read as follows:

Authority: Secs. 1102, 1812(d), 1814(b), 1815, 1833(a),(i) and (n), 1861(v), 1871, 1881, 1883, and 1886 of the Social Security Act (42 U.S.C. 1302, 1395f(b), 1395g, 1395l, 1395l(a),(i) and (n), 1395x(v), 1395hh, 1395rr, 1395tt, and 1395ww).

Subpart A -- Introduction and General Rules

2. Section 413.1 is amended by:

A. Revising paragraph (d)(2)(ii).

B. Adding paragraphs (d)(2)(iv) and (d)(2)(v).

§ **413.1 Introduction.**

* * * * *

(d) * * *

(2) * * *

(ii) Payment to children's, psychiatric, and long-term hospitals (as well as separate psychiatric units (distinct parts) of short-term general hospitals), that are excluded from the prospective payment systems under subpart B of part

412 of this subchapter, and hospitals outside the 50 States and the District of Columbia is on a reasonable cost basis, subject to the provisions of § 413.40.

* * * * *

(iv) For cost reporting periods beginning before April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals), that are excluded under subpart B of part 412 of this subchapter from the prospective payment systems is on a reasonable cost basis, subject to the provisions of § 413.40.

(v) For cost reporting periods beginning on or after April 1, 2001, payment to rehabilitation hospitals (as well as separate rehabilitation units (distinct parts) of short-term general hospitals) that meet the conditions of § 412.604 of this chapter is based on prospectively determined rates under subpart P of part 412 of this subchapter.

* * * * *

Subpart C-- Limits on Cost Reimbursement

3. Section 413.40 is amended by:

A. Republishing the introductory text of paragraph (a)(2)(i).

B. Adding a new paragraph (a)(2)(i)(C).

C. Revising paragraph (a)(2)(ii).

D. Adding a new paragraph (a)(2)(iii).

§ 413.40 Ceiling on the rate of increase in hospital inpatient costs.

(a) Introduction. * * *

(2) Applicability. (i) This section is not applicable to--

* * * * *

(C) Rehabilitation hospitals and rehabilitation units that are paid under the prospective payment system for inpatient hospital services in accordance with section 1886(j) of the Act and subpart P of part 412 of this subchapter for cost reporting periods beginning on or after October 1, 2002.

(ii) For cost reporting periods beginning on or after October 1, 1983, this section applies to--

(A) Hospitals excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter; and

(B) Psychiatric and rehabilitation units excluded from the prospective payment systems, as described in § 412.1(a)(1) of this chapter and in accordance with §§ 412.25 through 412.30 of this chapter, except as limited by paragraph (a)(2)(iii) of this section with respect to rehabilitation hospitals and rehabilitation units specified

in §§ 412.23(b), 412.27, and 412.29 of this subchapter.

(iii) For cost reporting periods beginning on or after October 1, 1983 and before April 1, 2001, this section applies to rehabilitation hospitals and rehabilitation units that are excluded from the prospective payment systems described in § 412.1(a)(1) of this subchapter.

* * * * *

Subpart E-- Payments to Providers

4. In § 413.64 paragraph (h)(2)(i) is revised to read as follows:

§ 413.64 Payment to providers: Specific rules.

* * * * *

(h) Periodic interim payment method of reimbursement--

* * *

(2) * * *

(i) Part A inpatient services furnished in hospitals that are excluded from the prospective payment systems, described in § 412.1(a)(1) of this chapter, under subpart B of part 412 of this chapter or are paid under the prospective payment system described in subpart P of part 412 of this chapter.

* * * * *

(Catalog of Federal Domestic Assistance Program No. 93.778, Medical Assistance Program)

Dated: _____

_____

Nancy-Ann Min DeParle,

Administrator,

Health Care Financing

Administration.

Dated: _____

_____

Donna E. Shalala,

Secretary.

BILLING CODE 4120-01